SEXUAL OFFENDING

Introduction

Sexual offenses perpetrated by juveniles are a serious problem. Each year in the United States, an estimated one-fifth of the rapes are committed by juveniles. One-half of the child molestations are committed by juveniles (Hunter, 2000). It is believed that approximately half of all adult sexual offenders began their criminal careers during adolescence (Saleh, 2004). The Federal Bureau of Investigation reported that, in 2001, approximately 12% of all rapes resulted in the arrest of a juvenile (Saleh). In Virginia's Department of Juvenile Justice system, almost 10% of the male population has a sex offense charge (Virginia Department of Juvenile Justice, 2004). Sexual offending is not a disorder per se, but is rather a behavioral problem that may be closely linked to other disorders.

Juveniles who perpetrate sexual offenses are defined as those who commit any sexual act against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner (Matthews, 1997). They are usually between 12 and 17 years of age and are mostly male, although some studies have found a number of females and prepubescent perpetrators (Hunter, 2000). Sexually abusive behaviors can vary from non-contact offenses to acts of penetration (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2001).

There are two types of juvenile sexual offenders: those who target children and those who offend against their peers or adults (Hunter, 2000). The type of offense is based on factors such as

the age and sex of the victim, the relationship between the victim and the offender, and the amount of force used (OJJDP, 2001). Table 1 outlines the characteristics of sexually abusive juveniles.

Characteristics of Juvenile Sexual Offending

Sexual and physical abuse, child neglect, and exposure to family/domestic violence are associated with juvenile sexual offending (Center for Sex Offender Management, 1999). Juvenile sexual offenders may be characterized as loners with few close friends (Thakur, as cited by Kushner, 2004). Exposure to pornography has also been cited, but studies examining whether pornography leads to juvenile sexual offending have been inconclusive (OJJDP, 2001). Likewise, the association between substance abuse and juvenile sexual offending has not been fully established (Center for Sex Offender Management).

Table 1

Characteristics of Sexually Abusive Juveniles

Typically adolescents, age 12 to 17.
Mostly male perpetrators.
Difficulties with impulse control and judgment.
Up to 80% have a diagnosable psychiatric disorder.
30-60% exhibit learning disabilities and academic dysfunction.
20 to 50% have histories of physical abuse.
40 to 80% have histories of sexual abuse.

Sources: Center for Sex Offender Management, December 1999 and Hunter, 2000.

Comorbidity

Sexually abusive juveniles share other common characteristics, including:

- high rates of learning disabilities and academic dysfunction;
- the presence of other behavioral problems and conduct disorder (CD); and
- difficulties with impulse control and judgment. (Saleh, 2004)

Juvenile sexual offenders have also been known to demonstrate characteristics of paraphilia, which is an intense, repeated sexual arousal to unconventional stimuli (PsychDirect, 2004). Offenders with paraphilia tendencies were also reported to have high rates of psychiatric disorders (Saleh, 2004). Within a recent study of juvenile offenders, 95% had two or more paraphilias, 82% had a mood disorder, 55% with anxiety disorder, 55% with impulse control disorder, 71% with attention-deficit/hyperactivity disorder, 94% with CD, and 50% had a substance abuse disorder (Saleh).

Juvenile Female Sexual Offenders

There are few studies that address juvenile female sexual offenders. Furthermore, female sexual offending has been under-reported and under-represented in sexual offender literature, due to the difficulty of finding adequate samples of female participants (National Center on Sexual Behavior of Youth, 2004). For instance, re-offense rates for females and males cannot be compared because of unknown sexual and non-sexual re-offense rates for female sexual offenders (National Center on Sexual Behavior of Youth).

These studies have identified implications for treating the juvenile female sexual offender. One implication is that female sexual offenders are usually more likely to have histories of maltreatment, with physical abuse being apparent in 20% of studied cases and sexual abuse in 50% of studied cases (Mathews et al., 1997). Compared to those of juvenile males, the histories of the studied females reflected even more extensive and pervasive childhood maltreatment because many of these females were exposed to interpersonal aggression by both females and males (Mathews et al.). Moreover, the histories of these females revealed that they were victimized at younger ages and were more likely to have had multiple perpetrators (Mathews et al.).

Juvenile female sexual offenders may molest children of both genders, with the victims typically being relatives or acquaintances of the perpetrator (Mathews et al., 1997). Many of the victims of female sexual offenders were frequently molested in the context of baby-sitting. Preliminary research has also revealed that these females had very disruptive and tumultuous childhoods, with high levels of trauma and exposure to dysfunction. High levels of impulsive delinquent behaviors, including substance abuse and other high-risk behaviors, were also observed (Mathews et al.). Studies are being conducted to ascertain effective treatments. However, preliminary results indicate that treatment approaches should be employed to address the early and repetitive developmental traumas experienced by these offenders.

Treatments

Funding problems and ethical issues have made it difficult to conduct controlled outcome studies on the treatment of juvenile sexual offenders. However, a number of encouraging clinical reports have been published. Treatment for young children with sexual behavior problems has been evaluated in two randomized trials (Bonner et al. & Pithers et al., as cited by Chaffin & Friedrich, 2004). Treatments were compared but the key finding from these studies were that the overall prognosis for children with sexual behavior problems is good and that sexually abusive juveniles can benefit from treatment.

Adolescent sex offenders differ from their adult counterparts in that juveniles generally do not present the same kinds or levels of sexual deviancy and psychopathic tendencies that may be observed among adult offenders (Saunders et al., 2001).

Promising sexual offender treatment programs often combine an intensive, multi-modal approach with early intervention. Comprehensive cognitive-behavior programs may focus on taking responsibility for one's sexual behavior, developing victim empathy, and developing skills to prevent future offending. Treatment approaches for juveniles can vary, from biochemical treatment to group therapy to cognitive behavioral therapy (Juvenile Justice Evaluation Center, 2002).

Another promising treatment currently being researched is drug treatment from the opioid antagonists' class. This is being studied to determine the drug's ability to safely control sexual impulses and arousal in adolescent sexual offenders (Ryback, as cited by Reuters Health Information, 2004).

Goals of Treatment

According to Saleh (2004), treatment of juvenile sexual offenders focuses on key objectives: confronting the sexual offender's denial; decreasing deviant sexual arousal; developing sexual interests of a nondeviant nature; promoting empathy with the victim; enhancing interpersonal and

social skills; clarifying values; clarifying cognitive distortions; and recognizing internal and external antecedents of sexual offending behavior (American Academy of Child & Adolescent Psychiatry [AACAP], 1999). The principal goal of sexual offender treatment is to help the patient gain control over inappropriate and deviant sexual symptoms or impulses so that they may cease offending (Saleh).

Multisystemic Therapy

There is no array of juvenile sex-offender treatments having clinical trials that validate treatment effectiveness. However, multisystemic therapy (MST), which has been evaluated in two randomized trials treating highly delinquent juvenile sex offenders, has been shown to be beneficial for the treatment of these youth (Borduin & Schaeffer, as cited by Chaffin & Friedrich, 2004).

Multisystemic therapy (MST) is an intensive family and community-based treatment, which addresses the multiple factors of serious antisocial behavior in juvenile abusers. Treatment can involve any combination of the individual, family, and extra familial factors (e.g., peer, school, or neighborhood). MST promotes behavior change in the juvenile's natural environment, using the strengths of the juvenile's family, peers, school, and neighborhood to facilitate change (Center for Sex Offender Management, 1999).

Concepts derived from family systems therapy can be incorporated into service treatments for sexual offending (Schladale, 2002). These family-based treatments do not need to be limited to an intensive home-based approach (Schladale). Parents or guardians need to be involved in the assessment and treatment process (Schladale). The use of family therapy may be most beneficial in instances where incest has occurred, especially when the sexual offender will be rejoining the family after treatment (AACAP, 1999).

In perhaps the best-controlled study to date, MST was compared to individual therapy in the outpatient treatment of 16 adolescent sexual offenders. Using re-arrest records as a measure of recidivism (sexual and non-sexual), the two groups were compared at a three-year follow-up interval. Results revealed that juveniles receiving MST had recidivism rates of 12.5% for sexual offenses and 25% for non-sexual offenses, while those juveniles receiving individual therapy had recidivism rates of 75% for sexual offenses and 50% for non-sexual offenses (Hunter, 2000).

Group Therapy

Group sessions are often used in hospital or residential treatment settings and for monitoring a behavioral management system. This therapy provides a setting in which it is difficult for the sex offender to minimize, deny, or rationalize his sexual behavior. It can be offered within a variety of settings dependent upon environment, group membership, severity of sexual offenses, group objectives or goals, open or closed, as well as the length of the group experience (AACAP, 1999).

Residential Sexual Offender Treatment

Juveniles who have significant offending histories and/or are deemed to be at a high risk to sexually reoffend are appropriate for residential sexual offender treatment, which ensures public and community safety, and simultaneously provides juveniles with intensive treatment that addresses both sexual and non-sexual behaviors. Residential programs provide intensive milieu treatment that is delivered by trained staff in a highly structured setting. The key to a successful residential programming is individualizing treatment which allows each juvenile to address the unique and specific issues that are relevant to gaining control over their sexual and nonsexual behaviors. As a

result, the length of time a juvenile remains in the program varies, because it is contingent upon the severity of the juvenile's problematic behaviors and motivation in treatment.

In one recent study of 668 juveniles participating in residential sexual offender programs within Virginia's juvenile correctional centers, the recidivism rate based on re-arrests for sexual offenses was four percent (with an average time post-release of 4½ years) (Wieckowski et al., 2005). The projected recidivism rate for sexual offenses was 7.7%, when based on all juveniles reaching the 10-year post-release mark (Waite et al., 2005). Successful integration of juveniles from a residential program is based on continued services in the community. Juveniles who successfully complete a residential program respond best when they are provided a gradual reduction in supervision and treatment services based on their compliance with parole rules and application of material they learned in treatment.

Community-based Programming

Community-based programming for juvenile sexual offenders is gaining more attention. Recent research suggests that community-based programming can offer certain advantages, including shortening residential lengths of stay, reducing the number of juvenile sexual offenders placed in residential care settings, and improving the post-residential transitioning of youth back into community settings (Hunter et al., 2004). Economic and clinical considerations have also bolstered the need for effective community-based programming. Key concepts guiding community-based programming are recognition of the heterogeneity of the population, establishment of a seamless continuum of care, emphasis on the myriad of problems this population manifests, and integration of legal and clinical management (Hunter, et al.). Community-based programming may be an effective element to the treatment continuum for juvenile sexual offenders.

Virginia's Sexual Offender Treatment Program

The following information about Virginia's Juvenile Sex Offender programs is taken from the Virginia Department of Juvenile Justice's website (2004). The Virginia Department of Juvenile Justice (DJJ) created a Sexual Offender Treatment Program at the Ellen Allen Cottage at Hanover Juvenile Correctional Center in 1990. DJJ worked with the Division of Prevention Research in the Department of Psychiatric Medicine at the University of Virginia to create an evaluation of the treatment program, collect and analyze data pertaining to juvenile sexual offenders and produce a report that discusses the recidivism data for sexual offenders. With implementation of the program, 14 beds were allocated to the treatment of juveniles having a sexual offense background. Today, the program has grown to treating up to 150 adolescents per year.

Four of Virginia's juvenile correctional centers also provide sexual offender treatment services, utilizing specialized, self-contained units that house 10 to 24 juveniles each. In Fiscal Year 2004, the average length of stay was 28 months. Juveniles entering the program receive a variety of individualized treatments including psychotherapy, group psychotherapy, family therapy, and treatment team meetings (Wieckowski et al., 2005).

DJJ projects the recidivism rate for those who have completed the program to be 4.7% after five years and 6.9% after 10 years (Wieckowski et al., 2005). The recidivism rate, as of 2006, is outlined in Table 2.

Table 2

Youth Labeled as Sex Offenders and Rearrested for a Sex Offense

Year of Release	Number Released	Number Rearrested Since Release	Percentage Rearrested
2001	115	5	4.3%
2002	115	4	3.5%
2003	92	4	4.3%
2004	98	7	7.1%
2005	101	0	0.0%

Source: *Data from DJJ Research Unit, FY 2006,* Virginia Department of Juvenile Justice, 2007.

DJJ study findings indicate that sexual recidivism rates for juvenile sexual offenders are lower than those of adult offenders and that youth participating in a self-contained sexual offender treatment program are less likely to participate in criminal activity after release. This is particularly true for the non-sexual assault offenders. The study offers two important findings:

- rates of recidivism, based on re-arrests, for sexual offenses among juvenile sex offenders are low and are not based on the type of treatment during incarceration, and
- high impulsive/antisocial behaviors significantly increase the probability of recidivism, regardless of type of treatment during incarceration (Wieckowski et al., 2005).

Psychopharmacological Treatments

In treating sexual offenders, selective serotonin reuptake inhibitors (SSRIs) have been shown to have an impact on sexual preoccupations, sexual drive, and arousal (AACAP, 1999). Further information about SSRIs is provided in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Treatment of sexual offenders through the use of antiandrogen drugs should be reserved for the most severe sexual abusers and is discouraged for use for juvenile sexual offenders under the age of 17 (AACAP, 1999). In addition, these drugs should never be used as an exclusive treatment (AACAP).

Treatment Implications

According to Saleh, informed consent is critical in treating sexual offenders (2004). Parents, as well as patients, need to be informed about the nature of the condition. The prognosis, nature, and purpose of treatment, as well as the risks associated with treatment, should all be addressed prior to beginning treatment.

Early interruption of a sexual abuse cycle can potentially prevent the sexual behaviors from becoming entrenched and reinforced (Westchester Juvenile Sex Offender and Sexually Aggressive Youth Planning Committee, 2000). Treatment which involves law enforcement, the offending adolescent and their families can provide a valuable opportunity to reduce the incidents and recidivism of sexual offending (Westchester Juvenile Sex Offender and Sexually Aggressive Youth Planning Committee).

Promising Approaches to Intervention

The following is a review of issues elements to the development of successful community-based and residential treatment programming for sexually abusive juvenile (Center for Sex Offender Management, 1999).

Coordination between the Criminal Justice System and Treatment Providers

Most treatment specialists believe that successful programming for sexually abusive juveniles requires a coordinated effort between the juvenile justice system staff and treatment providers. As supported by clinical experience, effective motivators for treatment include suspending a low-risk juvenile's sentence contingent upon his or her successful completion of a community-based treatment program, and making the high-risk juvenile's release contingent upon successful completion of a residential program.

Supervision

To date, no studies have clearly identified which supervision strategies are most effective with juveniles who commit sexual offenses. Adult sexual offender supervision utilizes these management strategies: intensive supervision and sexual offense specific treatment; interagency collaboration, multidisciplinary teams, and the specialization of supervision and treatment staff; the use of the polygraph to monitor therapy and compliance with supervision conditions; and program monitoring and evaluation. However, too little is known as yet about young perpetrators to apply adult standards to them.

Role of Supervision Officers

In many programs, parole and probation officers play an integral role in assisting treatment providers by addressing critical issues and supervising juveniles' activities in the home and community and being aware of the juveniles' behavior and progress in residential treatment programs. Parole and probation officers are a key element in helping juveniles transition from a residential to community-based treatment program. While there is little agreement among the treatment community about the proper role of supervision officers in the treatment of young sexual abusers, supervision officers should, at a minimum, communicate and collaborate with treatment providers (Center for Sex Offender Management, 1999).

Assessment

Careful screening is critical to match the juvenile's needs to the type and level of treatment, which can range from community-based programming to intensive residential treatment. Ideally, this assessment reflects the careful consideration of the danger that the perpetrator presents to the community, the severity of psychiatric and psychosexual problems, and the juvenile's amenability to treatment. Community-based programs should not compromise community safety by admitting juveniles who are aggressive and violent.

Clinical Assessment

Professional evaluation of juveniles and their appropriateness for placement should be conducted post-adjudication and prior to court sentencing. Clinical assessments should be comprehensive and include careful record reviews, clinical interviewing, and screening for co-occurring psychiatric disorders.

Assessment of the Juvenile's Home

Assessments of the juvenile's appropriateness for community-based programming should include a thorough review of his living arrangements, as well as a determination of whether the parents are capable of providing supervision. It is essential that the community and other children are protected from potential harm, both physical and psychological.

Clinical Programming

Clinical programming for sexually abusive juveniles typically includes a combination of individual, group, and family therapies. In addition, many programs offer supportive educational groups to families of these juveniles. Juveniles who display more extensive psychiatric or behavioral problems, such as substance abuse, may require additional treatment, including drug or alcohol rehabilitation and psychiatric care. All therapies provided to sexually abusive juveniles should be carefully coordinated within the treatment agency and with external agencies providing case management and oversight.

According to the Center for Sex Offender Management (1999), providers have established these as essential components of the treatment process for juveniles who commit sexual offenses:

- Gaining control of behavior;
- Teaching the impulse control and coping skills needed to successfully manage sexual and aggressive impulses;
- Teaching assertiveness skills and conflict resolution skills to manage anger and resolve interpersonal disputes;
- Enhancing social skills to promote greater self-confidence and social competency;
- Programming designed to enhance empathy and promote a greater appreciation for the negative impact of sexual abuse on victims and their families;
- Provisions for relapse prevention. This includes teaching juveniles to understand the cycle of thoughts, feelings, and events that are antecedent to the sexual acting-out, identify environmental circumstances and thinking patterns that should be avoided because of increased risk of reoffending, and identify and practice coping and self-control skills necessary for successful behavior management;
- Establishing positive self-esteem and pride in one's cultural heritage;
- Teaching and clarifying values related to respect for self and others, and a commitment to stop interpersonal violence. The most effective programs promote a sense of healthy identity, mutual respect in male-female relationships, and a respect for cultural diversity; and
- Providing sexual education to give an understanding of healthy sexual behavior and to correct distorted or erroneous beliefs about sexual behavior.

Qualifications of Sex Offender Treatment Providers

The following information is taken from a personal communication with Dennis Waite, Ph.D. (December 18, 2007). Due to the potential risk to the community of ineffective treatment for sex offenders, the Virginia General Assembly passed legislation in 1997 to create a certification process for clinicians who provide service to sex offenders. While licensed practitioners are required to practice only within the scope of their expertise (i.e., one could not provide sex offender treatment unless qualified to do so), a certification as a sex offender treatment provider (CSOTP) offers additional evidence of a specific expertise in this area. When seeking professional services for sex offenders, it is prudent to ensure that the qualifications of the service provider indicate expertise in the treatment of sex offenders. One way to ensure such expertise is to select a professional with this

certification (CSOTP). Qualifications include a minimum of a Master's Degree in selected fields, 50 hours of sex offender treatment-specific training, 2,000 hours of post-degree clinical experience, of which 200 must be face-to-face treatment/assessment of sex offenders, and 100 hours of clinical supervision (Virginia Board of Psychology, *Regulations Governing the Certification of Sex Offender Treatment Providers*, 18 VAC 125-30 et seq.).

Controversial Treatments

Some areas of practice are considered ethically and legally controversial and may create special problems for juvenile sexual offending practitioners (Center for Sex Offender Management, 1999). These include pre-adjudication evaluations, sexual offense risk assessments, phallometric assessments, and polygraphs. At issue are these treatments' lack of overall effectiveness and validity within a juvenile population.

Sources

American Academy of Child & Adolescent Psychiatry (AACAP). (1999). *Practice Parameters for the Assessment and Treatment of Children and Adolescents Who Are Sexually Abusive of Others, 38* (12), 55-76.

Center for Sex Offender Management. (1999). Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches and Management Practices. A Project of the Cities of Justice Programs, U.S. Department of Justice. [Online]. Available: http://www.csom.org/pubs/juvbrf10.pdf. [August 2005].

Chaffin, M., & Friedrick, B. (2004). *Children and Youth Services Review, 26*, 1097–1113. [Online]. Available: http://www.cachildwelfareclearinghouse.org/files/EBP%20in%20child%20abuse%20and%20neglect--Chaffin%20and%20Friedrich.pdf. [December 2007].

Hunter, J. (2000). Understanding Juvenile Sex Offenders: Research Findings & Guidelines for Effective Management & Treatment. *Juvenile Justice Fact Sheet*. Charlottesville, VA: Institute of Law, Psychiatry, & Public Policy, University of Virginia.

Hunter, J., Gilbertson, S., Vedros, D., & Morton, M. (2004). Strengthening Community-Based Programming for Juvenile Sexual Offenders: Key Concepts and Paradigm Shifts. *Child Maltreatment, 9 (2)*, 177-189.

Juvenile Justice Evaluation Center. (2002). [Online]. Available: http://www.jrsa.org/jjec. [August 2002].

Kushner, I. (2004). Megan's Law: Branding Juveniles as Sex Offenders. *Developments in Mental Health Law*. The Institute of Law, Psychiatry & Public Policy – University of Virginia, *23 (1)*, 10-23.

Mathews, F. (1997). Adolescent Sex Offenders. *National Clearinghouse on Family Violence*. [Online]. Available: http://www.hc-sc.gc.ca/hppb/familyviolence/html/nfntsxadolinfractions_e.html**.** [August 2005].

Mathews, R., Hunter, J., & Vuz, J. (1997). Juvenile Female Sexual Offenders: Clinical Characteristics and Treatment Issues. *Sexual Abuse: A Journal of Research and Treatment, 9* (3), 187-199.

National Center on Sexual Behavior of Youth. (2004). *NCSBY Fact Sheet*: What Research Shows About Female Adolescent Sex Offenders. [Online]. Available: http://www.ncsby.org/pages/publications/Female%20ASO.pdf. [October 2007].

Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2001). *Juveniles Who Have Sexually Offended*.

PsychDirect. (2004). Evidence Based Mental Health Education & Information: Paraphilias. [Online]. Available: http://www.psychdirect.com/forensic/Criminology/para/paraphilia.htm. [March 2005]. *Not available December 2007.*

Reuters Health Information. (2004). *Naltrexone Useful in Treatment of Adolescent Sex Offenders.* [Online]. Available: http://www.somersetmedicalcenter.com/112127.cfm. [July 2005].

Saleh, F. (2004). Juveniles Who Commit Sex Crimes. *Adolescent Psychiatry.* [Online]. Available: http://www.findarticles.com/p/articles/mi_qa3882/is_200401/ai_n9383794. [February 2005].

Saunders, B., Berliner, L., & Hanson, R. (2001). *Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse* (Final Draft Report: July 30, 2001). Charleston, SC.

Schladale, J. (2002). *A Collaborative Approach for Engaging Families in Treatment with Sexually Aggressive Youth*. [Online]. Available: http://www.resourcesforresolvingviolence.com/ResourceArticle1.htm. [March 2005].

Virginia Administrative Code. (1997). Virginia Board of Psychology, Regulations Governing the Certification of Sex Offender Treatment Providers, 18 VAC 125-30 et seq.

Virginia Department of Juvenile Justice (DJJ). (2004). *Virginia is a Leader in Treating Juvenile Sex Offenders.* [Online]. Available: http://www.djj.state.va.us/index_information/treatment_sex_offenders.php. [January 2005].

Virginia Department of Juvenile Justice (DJJ). (2007). *Presentation to the Judicial Liaison Committee* dated May 4, 2007. [Online]. Available: http://www.djj.virginia.gov/Resources/DJJ_Presentations/ppt/sex_offender_treatment_program.ppt#460,10,Youth Labeled as Sex Offenders at the JCC: Rearrested for a Sex Offense. [December 2007].

Waite, D., Keller, A., Pinkerton, R., Wieckowski, E., McGarvey, E., & Brown, L. (2005). Juvenile Sex Offender Re-Arrest Rates for Sexual, Violent Non-Sexual & Property Crimes: A Ten-Year Follow-Up. *Sexual Abuse: A Journal of Research and Treatment, 17 (3)*, 313-331.

Westchester Juvenile Sex Offender and Sexually Aggressive Youth Planning Committee. (2000). Position Paper, Reviewed 2/6/2004.

Wieckowski, E., Waite, D., Pinkerton, R., McGarvey, E., & Brown, L. (2005). Sex Offender Treatment in a Juvenile Correctional Setting: Program Description and Nine-Year Outcome Study. *Children and Young People Who Sexually Abuse: New Theory, Research and Practice Developments.* UK, Russell House Publishing Co.

Additional Resources

Bateman, P., & Mahoney, B. (1989). *Macho: Is that what I really want?* Scarborough, NY: Youth Education Systems.

Bays, L., & Freeman-Longo, R. *How Can I Stop? Breaking My Deviant Cycle.* Orwell, VT: Safer Society Press.

Harvey, W., & McGuire, T. (1989). *So, There Are Laws About Sex.* Toronto: Butterworths.

Johnson, S. (1992). *Man to Man: When Your Partner Says No*. Orwell, VT: Safer Society Press.

From the National Clearinghouse on Family Violence:

Mathews, F. (1996). *The Invisible Boy: Revisioning the Victimization of Male Children and Teens.* Ottawa: NCFV - Health Canada

Mathews, F. (1995) *Making the Decision to Care: Guys and Sexual Assault*. Ottawa: NCFV - Health Canada

Ryerse, C. (1996). *National Inventory of Treatment Programs for Child Sexual Abuse Offenders.* Ottawa: NCFV - Health Canada

Organizations/Weblinks

The Awareness Center

Sexually Reactive Children and Juvenile Sex Offenders
http://www.the awarenesscenter.org/JuvenileSexOffenders.html

Focus Adolescent Services

Adolescent Sex Offenders
877-362-8727 or 410-341-4342
http://www.focusas.com/AdolescentSexOffenders.html

Institute for Family Centered Services (IFCS)

http://www.ifcsinc.com

Juvenile Forensic Evaluation Resource Center

Understanding Juvenile Sex Offenders: Research Findings and Guidelines for Effective Management and Treatment
http://www.ilppp.virginia.edu/Publications_and_Reports/UndJuvSexOff.html

Virginia Department of Juvenile Justice

http://www.djj.state.va.us/index_information/treatment_sex_offenders.php